EDITORIALS

Significant Others in Patient Care

SOMETHING SORT OF SCARY has been happening in patient care. The close and mutually satisfying relationship between physicians and patients still exists, but one can sense that this hitherto hallowed relationship seems to be losing ground, both quantitatively and qualitatively. Somehow it seems not to be fitting the times as well as it did. One wonders whether this is because physicians are changing, or because other changes are coming about in this field which has been largely the province of physicians who wanted to take care of patients and of patients who sought or needed the care of physicians. It is always a little unnerving when something that has been widely accepted as a given, or an article of faith, appears to lose general, unquestioned acceptance. Yet more and more physicians and more and more patients seem to be seeking alternatives to the stereotype of the trusted physician and the cooperative or compliant patient.

Some of what has been occurring is explained easily enough. It has to do with scientific progress and social change. The remarkable progress in medical science and technology during the last half century has caused many physicians to become so specialized that in reality they are superbly skilled technicians. This has been at the expense of interest, or even experience, in the broader aspects of patient care. Patients on the other hand are developing greater sophistication (or perhaps pseudosophistication) about medicine and health care, and are playing a more active role in decisions about their medical care and in determining where they will seek it and from whom they will accept it. All this has led to a curious deprofessionalization of the health professions, while at the same time many kinds of workers in the health field are either seeking professional status or trying to enhance what they have. This latter applies to nurses, pharmacists, podiatrists and optometrists, for example, while a number of technician specialties are gradually achieving recognition as professions. Then the egalitarian thrust in today's society tends to have a leveling effect across the board. And along with this there has been greater public and patient acceptance of methods and approaches to health care that physicians consider to be unscientific, unproved or even dangerous.

Therefore, it seems obvious that there are now significant others who are becoming increasingly involved in patient care, and that these are many. The pressures for independent practice by health professionals other than physicians are growing, as is the concept of equal pay for the same services regardless of the extent of training or qualifications of those who render the services. In another dimension, practitioners of chiropractic have now attained licensure in every state, and reimbursement for their services has been authorized by Medicare, Medicaid and many private insurance carriers. Such trends, of which these are examples, suggest that in the foreseeable future patient care may become considerably less structured or perhaps even something of a free-for-all. These problems may be made simpler or more complex by the surfeit or excess of physicians which is expected in the next decade or so.

While medicine is still clearly the recognized leader among all the health professions, it is no

longer safe to assume that this will always be so. It is time for the medical profession to look at its role of leadership and to strengthen it. Our leaders spend a great deal of time and energy—and our dollars—defending the ramparts. While this is surely necessary, it likely will not be enough. The medical profession has strong roots in medical science and in the art of understanding and working with people, and helping them to cope in a caring way. The skills that medicine brings to patient care should now be used to affirm and strengthen leadership in all of health care. The medical profession—whether in practice, academia or wherever—should hoist the flag of leadership in health care, and organized medicine should become a crucible in which the future of patient care is hammered out and shaped. The role should be one of sure and effective leadership, working closely and collaboratively with all the significant others in health care, whether health professionals or not.

—MSMW

Thyroid Nodules and Thyroid Cancer: Other Aspects

IN REVIEWING the surgical aspects of thyroid nodules and thyroid cancer elsewhere in this issue, Dr. Orlo Clark has presented documentation for widely held approaches to the problems faced by surgical specialists. The statistics cited by Dr. Clark define to some extent the problems that those of us who hold other notions encounter in giving advice to patients with thyroid nodules and possible thyroid cancer.

In our population of more than 220 million, a 4 percent incidence of thyroid nodules means that about 8.8 million persons will have need for medical advice about this condition. The statistic that 0.004 percent of the population will have thyroid cancer, if accepted without question, means that 8,800 persons will have the liabilities of this disease. Because in most of the 8.8 million persons the disease will develop over a long time, each of these persons could be the basis for many medical decisions on the significance of thyroid nodules.

I find it hard to accept that 10 percent to 15 percent of thyroid cancer is anaplastic, although few would dispute Dr. Clark's position that surgical removal is done for diagnosis, not for cure. If about one in eight persons with thyroid cancer had anaplastic cancer, then these 1,100 unfortunate persons would contribute almost half of the annual deaths, estimated at 1,150 in the United States, or 0.4 percent of all cancer deaths. Unless I have seen a very unusual population, that figure is much too high. An important consequence of this consideration is that other forms of thyroid cancer, including papillary cancer, do contribute a larger percentage of the total deaths from the disease than his figures indicate.

The problems of papillary cancer as a radiation-induced disease are introduced by Dr. Clark, but are not fully defined, probably in keeping with his restriction of content to surgical aspects. The induction of papillary cancer by radiation therapy has been much publicized recently, more than 25 years after the association was first recognized. Modan's figure of 6.5 rads for induction of thyroid cancer[1] is indeed frightening when viewed in the light of Table 2 in Dr. Clark's paper. Dr. Clark chose not to comment on the common practice of using iodine 131 scans in instances in which iodine 123 or technetium 99m scans provide inferior delineation. I continue to believe that the use of carcinogenic doses of radiation in diagnostic studies should be debated, as I first did with little success in 1957.[2]

The magnitude of the problem of induction of thyroid papillary cancer by radiation is unknown. Hundreds of thousands, quite possibly millions, of persons may have had their thyroid glands exposed to radiation dosages now known to carry the potential of cancer induction. Some investigators advocate adding this group of irradiated patients to those to be evaluated for thyroid nodules by the method recommended in Figure 1 in Dr. Clark's article, with total thyroidectomy to follow for those having even microscopic papillary cancer foci. The cost of such a program needs careful evaluation and must be measured in economic terms, morbidity and mortality. The benefit in the long run for each person is best measured by considering the average age at which death occurs from this disease; such data, although hard to come by, are very valuable in contrast to the rather inconsequential figures on survival after diagnosis. Clearly, unless harm is done by the treatment, earlier diagnosis will regularly be followed by more prolonged survival. More advanced age at time of death is a clear benefit.

Dr. Clark has provided a service in clearly stat-